INSTRUCTIONS TO COMPLETE THE NURSING FACILITY TRACKING FORM – NMO 4958E

The purpose of the Nursing Facility Tracking Form is to notify the Medicaid Central Office of any nursing facility admission, discharge or death for all Medicaid eligible recipients. The information provided on this form will initiate and/or update the system with necessary information so the nursing facility can bill for services rendered. This form is also used to track discharges that occur from the nursing facility based on recommendations of the PASRR II evaluation.

This form is to be used for Medicaid eligible residents only when Medicaid is the primary payment source. If the resident is admitted utilizing other insurance, do not submit this form until Medicaid becomes the primary payer.

To obtain an authorization to bill for services, the facility should submit the form within 72 hours of any admission, service level change, payment continuation (due to a previous time limitation) new or retro eligibility determination, Hospice disenrollment or Medicaid Managed Care disenrollment. Medicaid must also be notified within 72 hours in the event of a discharge, death, transfer, or Hospice enrollment.

For all submissions, complete the resident's demographic information at the top of the form. Do not leave any area blank.

The resident's Medicaid billing number, date of birth, Social Security number and name spelling must match Medicaid and Social Security records. Refer to resident's Medicaid card, Eligibility Notice of Decision or access the Electronic Verification System (EVS) for verification.

Upon admission, if the resident is Medicaid eligible, complete Section I and Section II of the tracking form. If the resident has discharged at the time of the submission, also complete Section III. If the resident is not Medicaid eligible upon admission, do not submit this form until Medicaid eligibility has been determined.

SECTION I: ADMISSION INFORMATION

a) Indicate the date the resident was admitted to the facility, regardless of payment source. This may differ from the payment beginning date.
b) Indicate whether a PASRR Level I Identification screening and PASRR II evaluation (if applicable) has been completed. If yes, indicate the completion date. If the PASRR is time limited, indicate the limitation date.
c) Indicate whether a Level of Care screening has been completed. If yes, indicate the completion date. If the screening is time limited, indicate the limitation date.

3. SECTION II: PAYMENT INFORMATION

a) Indicate the date you are requesting Medicaid payment to begin. This date should correspond with the reason for the payment request.
b) Complete the Reason for Payment Request. Indicate one choice as described below:

Admission: An admission to the facility and Medicaid is the primary payment source.
Service Level change: Any service level change between NF Standard and Ventilator Dependent or Pediatric Specialty Care I and II (a new LOC screening is required).

Payment Continuation: Requesting payment continuation due to a time limited PASRR or LOC screening (an updated PASRR or LOC screening is required).
Retro-Eligible: Service dates that become eligible prior to the existing billing authorization.
Eligibility reinstated: The resident has lost Medicaid eligibility for more than 6 months and the resident's eligibility has now been reinstated (the facility must submit the tracking form to obtain a new billing authorization).
Hospice Disenrollment: The resident elects to disenroll from the hospice program.
Medicaid Managed Care Disenrollment: The resident is disenrolled from the Medicaid Managed Care program.

c) Indicate the Service Level Category for this resident. If your choice is LOC prior to 1/1/02, indicate the appropriate level of care code (SNL-1, 2, 3 or ICL-1, 2, 3).

3. SECTION III: DISCHARGE INFORMATION

Upon discharge complete Section III of the tracking form and submit within 72 hours on any occurrence listed below:

a) Complete the date of discharge for the resident
b) Complete the Reason for Discharge. Indicate one choice as described below:

Home or Community Based Living: Home or any other community based, independent or group living situation.
Hospital: Admitted as an inpatient to a hospital. This does not include admission to an emergency room or observation bed.
Death: Resident deceased
Transfer: Transfer to another nursing facility. Indicate the name of the facility the resident transferred to.
Hospice Enrollment: The resident elects to enroll in the Hospice program while in the nursing facility. Indicate the name of the Hospice.
PASRR II Determination: Any discharge, regardless of pay source, directly related to a PASRR II recommendation. Indicate where the resident was discharged to.

Provide the name of the person completing this form, their e-mail address and the date the form was submitted. The comment area can be used for additional information regarding the submission.

This form can be completed and submitted on-line at our web site http://dhcfp.state.nv.us (see the on-line link) or the form may be downloaded for your convenience and mailed to: 1100 E. William Street, Suite 102, Carson City, NV 89701. The facility should retain a copy for their records.

For questions regarding this form, please contact Nevada Medicaid, Continuum of Care Unit, at (775) 684-3759.